From: Blair, Hunt
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Subject: HIT-HIE Update: October 7, 2010

Greetings Health Information Technology – Health Information Exchange stakeholders and interested parties:

It has been too long since I have had the opportunity to provide a detailed update on Vermont HIT-HIE activities, but the virtue of that delay is that there has been substantial activity on which to report. Warning: there is a fair amount of pretty granular detail in this Update, so only the most keenly interested will want to wade through all of it. The highlights are up top.

Next General Stakeholders Meeting: next Wednesday, October 13 – 2:30 to 4 p.m. at in the Large Conference Room at DVHA's office, 312 Hurricane Lane, Williston.
Call in #: 866-910-4857, pass code: 489421

Two main Agenda items for that meeting:

1. Discussion of deployment of state HIT Fund resources in SFY11 above and beyond support to VITL, the Blueprint's IT infrastructure, and other identified federal matching requirements.
2. Discussion of the formation and constituent representation of the new Privacy & Security Work Group being convened by the Division of Health Care Reform.

More on both of these topics below.

Medicaid "Meaningful Use" Provider Incentive Payments – we are *finally* approaching clarity on both the process and time line for 2011 launch of incentive program. There is a lot of detail both below and to come in the next few months, but the high level summary is that while much still remains to be resolved related to technical details, CMS has made significant progress in establishing the basic contours for how states will implement the program.

While I am not yet *quite* ready to make a promise for the Vermont start date for implementation of payments to Eligible Professionals and Hospitals – there remain important loops to be closed with CMS – I feel confident enough about the progress that *it looks as though* we will be able to begin those payments in July 2011.

More on how we plan to implement the incentive program below, but this reminder that VITL, as the Regional Extension Center grantee, has lead responsibility for working with providers to help prepare for meaningful use. Also remember that for the Medicaid incentives (in contrast to the Medicare incentives), payment in year one is for adoption, implementation, or upgrade of an EHR system; the meaningful use measures kick in for the second year of the program.

Also remember that under the Medicaid program, provider incentive payments do not have to be made in contiguous years. So you could elect to begin in the program in 2011 and then wait until 2013 or later to apply for additional incentive payments. The caveat is that the Meaningful Use measures "escalator" will rise over time, and so over time, the higher stage measures will apply for the year in which the incentives are requested. It's therefore still advantageous to get on and stay on the escalator early. A single page chart of the Medicaid payments incentives for Eligible Professionals is attached to this email and much, much more is available at www.vitl.net and in person with VITL staff and consultants whom you can arrange to meet by calling 802-223-4100.

Here's where we start to get into the weeds…

If we can implement the EHR incentive program sooner than 7/1/11 we will, but given the current remaining uncertainties around development of interfaces and other technical challenges, all remains provisional. To be perfectly clear, even the July 1, 2011 date is a hope, not a promise, at this stage.

I will say that the addition of HIT-HCR Project Manager Terry Bequette (pronounced Beckett) to the DVHA team has helped enormously in our capacity to focus expertise on the complex technical issues related to implementing the program. Terry has already become expert in the dogged pursuit of extracting information from our sometime less than clear federal partners.

There are several "registration" steps that Eligible Professionals and Eligible Hospitals will need to take. The first step is to log into the NLR or National Level Repository, which is a web site CMS is developing (note that I didn't say "has developed") where providers will indicate whether they are choosing the Medicare or the Medicaid incentive program, if Medicaid, in what state, and entering an NPI (National Provider Identifier) number and TIN (Tax Identification Number).

The NLR then – through the still-in-development (notice a theme here?) electronic data interface between CMS and each state – makes that information available to state Medicaid agencies. Each state then has a secondary registration web portal where providers will enter more detailed information and validate the information submitted through the NLR which will be pre-populated on our state level web site. It is the details of these two steps that cause some concern about the actual implementation date of the program, because so many of the components are outside of our direct control.

Vermont has chosen to collaborate with a group of other states, led by Pennsylvania, who share HP (formerly EDS) as our claims processing / Medicaid Management Information Systems (MMIS) contractors, to build a common platform for the state level web portals. This will enable us to link directly to the HP system to generate the provider incentive payments. (Because this question has come up, let me clarify that

the state level provider incentive portal, while being developed with other HP states, is vendor agnostic and will work with whichever MMIS vendor the state selects through the upcoming procurement process.)

We'll have many more details to share about this process in the coming months, but we're quite excited about the features that we'll be able to automate through the web portal that should make participation in the incentive program pretty straightforward in terms of the bureaucratic and logistical steps. It will accommodate and the reporting of patient volumes and attestations related to adoption, implementation or upgrade and meaningful use.

Related to all of this, the first draft of our State Medicaid HIT Plan (SMHP) and HIT Implementation Planning Advanced Planning Document (HIT—IAPD) will be filed by month's end. It will provide additional detail on our plans for implementation of the incentive program, but here too I will add the caveat that I expect we'll be doing an update of the SMHP in the first half of 2011 to reflect additional information as CMS firms up things at the federal level.

By the way, speaking of planning documents, we are still awaiting feedback from the "technical review" of the *Vermont HIT Plan* submitted to ONC on August 31. For those who never got around to reading the VHITP, we now have it in "Wordle" form, which condenses the document to a single page view, with the most frequently used words appearing in larger fonts. It is attached.

Privacy & Security Work Group

As discussed at the September stakeholders meeting, we are forming a new Work Group to address emerging and on-going HIT-HIE Privacy & Security issues. Longtime observers of Vermont HIT policy will recall that VITL was originally charged with development of HIT policies, including those relating to privacy and security, but with Act 66 of 2009, that responsibility has been placed in the Division of Health Care Reform.

Accordingly, I am convening a group to provide advice to the State about updates and adjustments to the existing policies. It is important to note that we have a set of existing policies (which can be found in an Appendix of the VHITP), we are not embarking on a rewrite or substantial revision of those policies. Therefore, one of the qualifications necessary for serving on the Work Group is a general agreement to the underlying scope of the current policies and their role supporting the health care reform agenda and goals underpinning HIT-HIE policy.

Moreover, the role of this Work Group will be to provide advice, not to determine State policy moving forward, which is a different role than the Work Group VITL convened, during the period of time in which the State delegated that role to VITL. The meetings

will be open and public, and we are interested in hearing from diverse points of view, but ultimately the Commissioner will accept, reject, or modify the Work Group recommendations. It is also possible – and this will be on the Work Group's agenda – that there will be a recommendation that statutory language relating to the security and privacy of electronic health information, in which case there will be further opportunity for discussion and debate in the legislative forum.

As noted at the September meeting, I am looking for volunteers to participate in the Work Group who can commit to attending at least 75% of the monthly meetings we anticipate will take place over the coming 6 months to a year, as well as reviewing documents off-line between meetings. We want to have various constituencies represented (e.g., physicians, hospitals, designated agencies, free-standing mental health and substance abuse providers, home health, long term care, consumer and privacy advocates, and individual consumers) but keep the group to a manageable size. I am also asking the Health Care Reform Commission to recommend a legislative representative.

Issues on the docket already for the Work Group include:

1. 42 CFR Part 2 and the recent SAMHSA FAQ on same that requires adjustment to current policy related to exchange of alcohol and substance abuse records.
2. Discussion about exchange of minors' health information (particularly because of the different approaches our neighboring states have taken).
3. Restrictions on the exchange of information from self-pay encounters (raised by sections of the HITECH Act).
4. The federal Data Use and Reciprocal Support Agreement (DURSA) for use with the National Health Information Network.
5. And closely related to 4, the general subject of interstate HIE and cross-border issues that arise from differing state privacy and security policies and legislation.

And finally, two last areas to touch on briefly:

Provider Directories: a topic under discussion periodically here within the state has turned out to have national interest and significance. In short: in the world of electronic health exchange, how do we route health records to the correct doctor and correct EHR? How is the transaction authenticated? How do we look up or discover the correct e-address of the doctor or hospital or lab or other provider with whom we want to exchange health information?

ONC's HIT Policy Committee's Information Exchange work group (on which I have the privilege of serving) convened a Provider Directory task force which has been meeting intensively over the past few weeks to develop a set of recommendations to ONC. Last week, the task force held a public hearing in Washington. It was an intense and interesting day and has already been followed by two follow up task force conference calls, with a third scheduled for next week and a public meeting of the work group (by

conference call) next week as well. The goal is to provide recommendations on high level principles at the HIT Policy Committee's October meeting, with more specific recommendations to follow at its November and December meetings.

You can follow all of this activity via the ONC web site. This link provides slides and testimony from last week's hearing, and you can navigate to other areas from there: http://healthit.hhs.gov/portal/server.pt?open=512&objID=1474&&PageID=17114&mode=2&in_hi_userid=11673&cached=true My written testimony is there, but the actual subject matter experts material is of far greater interest.

Aside from being interesting (as some readers know, I have had an on-going interest in this subject for many years now), this has specific relevance for HIE in Vermont, as well as helping to solve the historic problem of not having "one true" authoritative source of record that authenticates who Vermont's providers are and where they practice. There are also opportunities we'll be exploring with other Departments and Agencies of State government to take advantage of the HIT-HIE resources to help develop a cross-cutting directory that would serve multiple purposes.

The State Health IT Fund: as presented at the September Health Care Reform Commission hearing and at the last stakeholders meeting, we are fortunate to have additional resources in the current SFY to devote to HIT-HIE infrastructure investment. As discussed last month, we are working with both the designated agencies and other MH/SA providers to talk about opportunities for extending HIE to their realm and supporting EHR adoption. In fact we have a meeting immediately before the next Stakeholders meeting so there will be a timely update provided then.

In addition, we anticipate the opportunity to build out the Blueprint HIT infrastructure – its clinical registry and reporting tool DocSite – to more people and locations over the coming year than previously expected in that time frame. Other opportunities continue to be explored, and as indicated above, this will be a subject for next week's meeting as well.

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